



PATIENT INFORMATION (ADULT)

Patient's Name: AHN MD, ANTHONY DOB: 09-24-1972 Date: 03-23-2016

Address: _____ Age: 43 Y/O Gender: M

City: _____ State: _____ Zip: _____ Home Phone: (917)826-9559

SSN: _____ Driver's Lic: _____ Cell Phone: _____

Email: _____

Patient Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

City: _____ State: _____ Zip: _____

Spouse's Name: _____ Phone: _____ Spouse's Employer: _____

Name of Referring Physician/Therapist/Trainer: _____

Name of Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Were you injured at work? (circle one) Yes No

Was the injury a result of an accident!? (circle one) Yes No

Was an automobile involved? (circle one) Yes No

INSURANCE INFORMATION

Person responsible for the payment?

- Self
- Spouse
- Parent
- Cash
- Auto
- Legal
- Worker's Comp

In addition to your insurance card this information must be fully completed in order for us to courtesy bill your insurance company.

PRIMARY Insurance Co: _____ Name of Policy Holder: _____

Insured Employer: _____ Insured DOB: _____ Relationship to self: _____

Insured SSN: _____ ID#: _____ Group#: _____

SECONDARY Insurance Co: _____ Name of Policy Holder: _____

Insured Employer: _____ Insured DOB: _____ Relationship to self: _____

Insured SSN: _____ ID#: _____ Group#: _____

If you checked "legal" above, please provide your attorney's name: _____

Address: _____ Phone: _____

******* AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS *******

If your check is returned by the bank, a \$20 service charge will be added to your account. I request that payment of authorized Medicare/ Other Insurance company benefits be made to Beach Cities Orthopedics and Sports Medicine for any services to me by the physician who accepts assignment. Regulations pertaining to Medicare apply. I authorize any holder of medical, or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information needed for this or related Medicare/ Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original. I understand that it is mandatory to notify the healthcare provider or any other party who may be responsible for paying for my treatment. (Section 1128B of the social Security Act and 31 U.S.C. 381-3812 provides penalties for withholding this information). Conditional payment of any charges resulting from 3rd party liability will be requested from the insurance company. At the time of settlement of 3rd party liability cases, insured will be responsible for reimbursing the insurance company payments made and the payment in full for any medical charges incurred in this office relating to said inquiry. I understand that payment is my obligation and responsibility, regardless of insurance and other third party involvement. I have read and understand possible financial responsibility for services rendered and hereby affix signature as acknowledgement of this understanding.

Signature of Patient

03-23-2016

Date